FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034991

Facility Name: PARK HOUSE

Address: 2320 S LAWNDALE (Number) CHICAGO (City) 60623 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3620976

Date of Initial License for Current Owners: 01/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA/PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1

(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	14	Skilled (SNF)	14	5,124	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,672	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	34,665			34,665	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,665			34,665	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 89.35%

D. How many bed-hold days during this year were paid by Public Aid?
940 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number PARK HOUSE # 0034991 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	131,106	12,653	4,240	147,999		147,999	2,176	150,175			1
2	Food Purchase		121,559		121,559		121,559	(337)	121,222			2
3	Housekeeping	115,556	12,484	0	128,040		128,040	0	128,040			3
4	Laundry	23,666	48,251	0	71,917		71,917	0	71,917			4
5	Heat and Other Utilities			61,340	61,340		61,340	286	61,626			5
6	Maintenance	15,399		66,918	82,317		82,317	7,080	89,397			6
7	Other (specify):*			11,163	11,163		11,163	0	11,163			7
8	**TOTAL General Services**	285,727	194,947	143,661	624,335		624,335	9,205	633,540			8
	B. Health Care and Programs											
9	Medical Director			1,700	1,700		1,700	0	1,700			9
10	Nursing and Medical Records	783,147	41,530	2,820	827,497		827,497	16,536	844,033			10
10a	Therapy	64,088	1,493	11,824	77,405		77,405	(3,173)	74,232			10a
11	Activities	62,827	7,376	2,391	72,594		72,594	0	72,594			11
12	Social Services	22,932		5,082	28,014		28,014	0	28,014			12
13	Nurse Aide Training			0				0				13
14	Program Transportation		1,240	0	1,240		1,240	0	1,240			14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	932,994	51,639	23,817	1,008,450		1,008,450	13,363	1,021,813			16
	C. General Administration											
17	Administrative	93,033		257,400	350,433		350,433	(145,833)	204,600			17
18	Directors Fees			0				0				18
19	Professional Services			164,436	164,436		164,436	(133,015)	31,421			19
20	Dues, Fees, Subscriptions & Promotions			16,970	16,970		16,970	(2,146)	14,824			20
21	Clerical & General Office Expense	77,006	6,617	68,648	152,271		152,271	(7,730)	144,541			21
22	Employee Benefits & Payroll Taxes			233,525	233,525		233,525	0	233,525			22
23	Inservice Training & Education			0				671	671			23
24	Travel and Seminar			1,720	1,720		1,720	74	1,794			24
25	Other Admin. Staff Transportation			233	233		233	847	1,080			25
26	Insurance-Prop.Liab.Malpractice			25,286	25,286		25,286	2,518	27,804			26
27	Other (specify):*			0				17,532	17,532			27
28	**TOTAL General Administration**	170,039	6,617	768,218	944,874		944,874	(267,082)	677,792			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,388,760	253,203	935,696	2,577,659		2,577,659	(244,514)	2,333,145			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			27,950	27,950		27,950	43,588	71,538			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							266,627	266,627			32
33	Real Estate Taxes			62,726	62,726		62,726	0	62,726			33
34	Rent-Facility & Grounds			317,616	317,616		317,616	(313,807)	3,809			34
35	Rent-Equipment & Vehicles			17,255	17,255		17,255	4,755	22,010			35
36	Other (specify):*							0				36
37	TOTAL Ownership			425,547	425,547		425,547	1,163	426,710			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers							0				39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			58,194	58,194		58,194	0	58,194			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			58,194	58,194		58,194		58,194			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,388,760	253,203	1,419,437	3,061,400	0	3,061,400	(243,351)	2,818,049			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(1,048)	30		9
10	Interest and Other Investment Income	0	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(337)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(991)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(2,617)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(342)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(1,136)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,471)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(236,880)	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (236,880)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (243,351)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

STATE OF ILLINOIS **Page 5A**

Facility Name PARK HOUSE
ID# 0024991
Report Period Beginning: 01/01/2000
Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(187)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	(1,136)
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	(1,477)
9	**Non-Straightline Depreciation**	(1,048)	30	**Line 9**	0
10	**Interest and Other Investment Income**	0	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(337)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	0	20	**Line 16**	0
18	**Fines and Penalties**	(991)	21	**Line 17**	0
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	0	20	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(2,509)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21**	(99)
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	0	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(2,617)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	(342)	20	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(5,950)
30	**Donated Goods**	0	0	**Line 29**	(9,427)
31	**Amortization Expense**	0	0	**Line 30**	(1,048)
32	Deferred Maintenance	(1,136)	6	**Line 31**	0
33				**Line 32**	0
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	(7,540)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(6,477)
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Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(3,850)	6,026	0	0	0	0	0	0	0	0	2,176	1
2	Food Purchase	(337)	0	0	0	0	0	0	0	0	0	0	(337)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	286	0	0	0	0	0	0	0	0	286	5
6	Maintenance	(1,136)	0	8,216	0	0	0	0	0	0	0	0	7,080	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,473)	(3,850)	14,528	0	0	0	0	0	0	0	0	9,205	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	16,536	0	0	0	0	0	0	0	0	16,536	10
10a	Therapy	0	(10,800)	7,627	0	0	0	0	0	0	0	0	(3,173)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	(10,800)	24,163	0	0	0	0	0	0	0	0	13,363	16
	C. General Administration													
17	Administrative	0	(180,400)	34,567	0	0	0	0	0	0	0	0	(145,833)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(135,300)	2,285	0	0	0	0	0	0	0	0	(133,015)	19
20	Fees, Subscriptions & Promotions	(2,959)	0	813	0	0	0	0	0	0	0	0	(2,146)	20
21	Clerical & General Office Expenses	(991)	(46,618)	39,879	0	0	0	0	0	0	0	0	(7,730)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	671	0	0	0	0	0	0	0	0	671	23
24	Travel and Seminar	0	0	74	0	0	0	0	0	0	0	0	74	24
25	Other Admin. Staff Transportation	0	0	847	0	0	0	0	0	0	0	0	847	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,518	0	0	0	0	0	0	0	0	2,518	26
27	Other (specify):*	0	0	17,532	0	0	0	0	0	0	0	0	17,532	27
28	**TOTAL General Administration**	(3,950)	(362,318)	99,186	0	0	0	0	0	0	0	0	(267,082)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,423)	(376,968)	137,877	0	0	0	0	0	0	0	0	(244,514)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary B

Facility Name & ID Numb PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(1,048)	38,397	6,239	0	0	0	0	0	0	0	0	43,588	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	266,001	626	0	0	0	0	0	0	0	0	266,627	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(317,616)	3,809	0	0	0	0	0	0	0	0	(313,807)	34
35	Rent-Equipment & Vehicles	0	0	4,755	0	0	0	0	0	0	0	0	4,755	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,048)	(13,218)	15,429	0	0	0	0	0	0	0	0	1,163	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(6,471)	(390,186)	153,306	0	0	0	0	0	0	0	0	(243,351)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe PARK HOUSE # 0024991 Report Period Beginning 01/01/2000 Ending: 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
SEE ATTACHED SCHEDULE				CAREPLUS REHABILITATIVE SERVICES		
					NILES	THERAPY
				2320 S LAWNDALE	NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
V	17	MANAGEMENT FEES	180,400	CAREPLUS MGMT INC	0	0	(180,400)	1	-180400
V	19	ADMIN. CONSULTANT FEES	126,500	" "			(126,500)	2	-126500
V	19	DATA PROCESSING FEES	8,800	" "			(8,800)	3	-8800
V	21	CLERICAL FEES	46,640	" "			(46,640)	4	-46640
V	1	DIETARY CONSULTANT FEE	2,850	" "			(2,850)	5	-3850
V				" "				6	
V								7	
V	10a	THERAPY SERVICE	10,800	CAREPLUS REHABILITATIVE SERVICE			(10,800)	8	-10800
V								9	
V	21	RENT	317,616	2320 S LAWNDALE LLC			(317,616)	10	-317616
V	30	NL DEPRECIATION		" "		38,397	38,397	11	38397
V	22	INTEREST		" "		266,001	266,001	12	266001
V	21	OFFICE EXPENSE		" "		22	22	13	22
Total			$ 694,606			$ 304,420	$ (390,186)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	DIETARY SALARIES	$	CAREPLUS MGMT INC		$ 6,026	$ 6,026	15	6026
16	V	5	ELECTRICITY		" "		286	286	16	286
17	V	6	REPAIRS		" "		505	505	17	505
18	V	6	MAINTENANCE SALARIES		" "		7,711	7,711	18	7711
19	V	10	NURSING		" "		16,536	16,536	19	16536
20	V	10a	THERAPY SALARIES		" "		0		20	
21	V	17	ADMIN SALARIES		" "		34,567	34,567	21	34567
22	V	19	PROFESSIONAL FEES		" "		2,285	2,285	22	2285
23	V	20	DUES/LICENSES/WANT ADS		" "		813	813	23	813
24	V	21	OFFICE SALARIES/EXPENSES		" "		39,879	39,879	24	39879
25	V	23	SEMINARS		" "		671	671	25	671
26	V	24	TRAVEL		" "		74	74	26	74
27	V	25	TRANSPORTATION		" "		847	847	27	847
28	V	26	INSURANCE		" "		2,518	2,518	28	2518
29	V	27	EMPLOYEE BENEFITS		" "		17,532	17,532	29	17532
30	V	30	SL DEPRECIATION		" "		6,239	6,239	30	6239
31	V	32	INTEREST		" "		626	626	31	626
32	V	34	OFFICE RENT		" "		3,809	3,809	32	3809
33	V	35	EQUIP RENT/AUTO LEASE		" "		4,755	4,755	33	4755
34	V								34	
35	V								35	
36	V								36	
37	V	10a	THERAPY SERVICES		CAREPLUS REHABILITATIVE SERVICES		7,627	7,627	37	7627
38	V								38	
39	Total			$			$ 153,306	$ * 153,306	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6

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Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	JAKOB BAKST	DIR OPERATION	ADMIN, CONSU	18.10	SEE ATTACHED	3.2	5.34	SALARY	9,887	17-7	2
3	SHERWIN I. RAY	PRESIDENT	ADMIN, FINAN	31.90	SCHEDULES	3.2	5.34	" "	9,887	17-7	3
4			BANKING								4
5											5
6											6
7											7
8	ERIC ROTHNER (HUNTER LLC)		ADMIN,CONSU	25.00	" "	0.19		MGMT FEE	77,000	17-3	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 96,774		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT C... Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio	CAREPLUS MGMT	EXTENDED CAI
Street Address	5940 W TOUHY	5301 W TOUHY
City / State / Zip Code	NILES, IL 60714	SKOKIE, IL 6007
Phone Number	(847) 647-1717	(847) 674-1180
Fax Number	(847) 647-0222	(847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	559,284	11	$ 97,227	$ 97,227	34,665	$ 6,026	1
2	5	ELECTRICITY	" "	648,651	14	5,352		34,665	286	2
3	6	REPAIRS	" "	648,651	14	9,448		34,665	505	3
4	6	MAINTENANCE SALARIES	" "	648,651	14	144,297	144,297	34,665	7,711	4
5	10	NURSING	" "	648,651	14	309,417	309,417	34,665	16,536	5
6	10a	THERAPY SALARIES	" "	578,314	12	73,756	73,756			6
7	17	ADMIN SALARIES	" "	648,651	14	646,825	646,825	34,665	34,567	7
8	19	PROFESSIONAL FEES	" "	648,651	14	42,748		34,665	2,285	8
9	20	DUES/LICENSES/WANT AI	" "	648,651	14	15,220		34,665	813	9
10	21	OFFICE SALARIES/EXPEN	" "	648,651	14	746,225	559,379	34,665	39,880	10
11	23	SEMINARS	" "	648,651	14	12,554		34,665	671	11
12	24	TRAVEL	" "	648,651	14	1,390		34,665	74	12
13	25	TRANSPORTATION	" "	648,651	14	15,846		34,665	847	13
14	26	INSURANCE	" "	648,651	14	47,123		34,665	2,518	14
15	27	EMPLOYEE BENEFITS	" "	648,651	14	328,053		34,665	17,532	15
16	30	SL DEPRECIATION	" "	648,651	14	116,734		34,665	6,238	16
17	32	INTEREST	" "	648,651	14	11,707		34,665	626	17
18	34	OFFICE RENT	" "	648,651	14	71,276		34,665	3,809	18
19	35	EQUIP RENT/AUTO LEASE	" "	648,651	14	88,968		34,665	4,755	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,784,166	$ 1,830,901		$ 145,679	25

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RE MGMT

7

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STATE OF ILLINOIS

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

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STATE OF ILLINOIS

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

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STATE OF ILLINOIS

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: 2320 S LAWNDALE LLC						$	$			$	1
2	NOMURA		X	MORTGAGE	$26,468.00	12/95	3,185,096	2,967,171	01/08	0.0888	266,001	2
3												3
4												4
5	CAREPLUS MANAGEMENT ALLOCATION: CIB BK LOC, ETC											5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$26,468.00		$ 3,185,096	$ 2,967,171			$ 266,001	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,185,096	$ 2,967,171			$ 266,001	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	64,220	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	63,156	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,064)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	63,790	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	62,726	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	47,977	8
	1996	47,158	9
	1997	62,474	10
	1998	63,583	11
	1999	63,156	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Numb PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,849 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	51,000	1995	$ 100,000	1
2					2
3	TOTALS	51,000		$ 100,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: 2320 S LAWNDALE LLC				$	$		$	$	$	4
5	106		1989		1,209,350	38,397	39	38,397		459,155	5
6											6
7											7
8	RELATED PARTY : CAREPLUS MANAGEMENT					57		57			8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	LEASEHOLD IMPROVEMENTS			1989	17,739	563	20	887	324	9,998	9
10	LEASEHOLD IMPROVEMENTS			1989	4,204	280	15	280		3,290	10
11	LEASEHOLD IMPROVEMENTS			1990	11,700	371	20	585	214	6,039	11
12	LEASEHOLD IMPROVEMENTS			1991	17,413	553	20	871	318	8,274	12
13	LEASEHOLD IMPROVEMENTS			1992	55,138	1,858	31.5	1,750	(108)	15,196	13
14	LEASEHOLD IMPROVEMENTS			1993	26,399	748	31.5	838	90	6,285	14
15	LEASEHOLD IMPROVEMENTS			1994	3,400	87	39	87		591	15
16	ROOF REPAIR			1995	1,500	38	39	38		211	16
17	ROOF-TOP HEAT/A/C			1996	10,000	256	39	256		1,249	17
18	CEILING TILE / DUMBWAITER REPAIR			1996	12,253	314	39	314		1,453	18
19	RE-ROOF			1996	80,861	2,073	39	2,073		8,981	19
20	FIXTURES / WINDOWS			1996	3,850	99	39	99		415	20
21	WINDOWS			1997	18,900	483	39	483		1,619	21
22	ROOF REPAIR & ROOF-TOP HEAT/A/C INSTALLATION			1997	3,228	82	39	82		290	22
23	DOOR & FLOORING			1997	2,922	75	39	75		266	23
24	ELEVATOR REPAIR			1997	3,125	80	39	80		270	24
25	WINDOWS			1998	12,600	323	39	323		889	25
26	TILE AND FLOORING			1998	23,810	611	39	611		1,665	26
27	ELECTRICAL, PLUMBING, AND ELEVATOR REPAIR			1998	31,238	801	39	801		2,111	27
28	NEW NURSES STATIONS			1998	24,271	622	39	622		1,789	28
29	WINDOW TREATMENTS AND BRAILLE SIGNS			1998	3,478	89	39	89		241	29
30	FIRE SYSTEM UPGRADE AND DAMPERS			1998	8,833	225	39	225		532	30
31	REAR PARKING LOT REPAIRS			1998	10,550	704	15	704		1,759	31
32	WINDOWS / CLOSETS / OUTLETS / DUMBWAITER / ROOI			1999	23,174	594	39	594		1,015	32
33	ROOF REPAIR			1999	18,365	471	39	471		726	33
34	FRONT RAMP REPAIR			2000	1,200	16	27.5	16		16	34
35	VINYL TILE / KITCHEN			2000	6,213	104	27.5	104		104	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 50,974		$ 51,812	$ 838	$ 534,429	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe PARK HOUSE # 0034991 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
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35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe PARK HOUSE # 0034991 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe PARK HOUSE # 0034991 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe PARK HOUSE # 0034991 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 129,053	$ 13,338	$ 11,887	$ (1,451)	3-15 YR	$ 74,637	37
38	Current Year Purchases	33,147	2,092	1,657	(435)	10 YR	1,657	38
39	Fully Depreciated Assets	59,171					59,171	39
40	RELATED PARTY		6,182	6,182				40
41	TOTALS	$ 221,371	$ 21,612	$ 19,726	$ (1,886)		$ 135,465	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 72,586	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 71,538	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (1,048)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 669,894	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the curre
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipm $ 17,255 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	1,316,974		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,312		6
7	Other Prepaid Expenses	53,703		7
8	Accounts Receivable (owners or related parties)	272,157		8
9	Other(specify): RE ESCROW	40,826		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,690,972	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	436,364		15
16	Equipment, at Historical Cost	221,372		16
17	Accumulated Depreciation (book methods)	(230,049)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): REP RESERVE	(9,371)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 418,316	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,109,288	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 464,082	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,264		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,026		31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,790		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 558,162	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	45,378		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 45,378	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 603,540	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,505,748	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,109,288	$	48

***(See instructions.)**

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,292,303	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	(39,579)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,252,724	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	463,024	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(210,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 253,024	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,505,748	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,519,436	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,519,436	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	3,085	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,085	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,622	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 2,622	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 3,525,143	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 624,335	31
32	Health Care	1,008,450	32
33	General Administration	944,874	33
	B. Capital Expense		
34	Ownership	425,547	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	58,194	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,061,400	40
41	**Income before Income Taxes (line 30 minus line 40)****	463,743	41
42	**Income Taxes**	719	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 463,024	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,684	4,828	$ 52,129	$ 10.80	1
2	Assistant Director of Nursing	1,014	830	17,519	21.11	2
3	Registered Nurses	1,936	2,106	47,468	22.54	3
4	Licensed Practical Nurses	12,606	13,623	236,787	17.38	4
5	Nurse Aides & Orderlies	46,737	50,137	429,244	8.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,660	6,491	64,088	9.87	8
9	Activity Director	2,847	3,069	31,462	10.25	9
10	Activity Assistants	3,906	4,214	31,365	7.44	10
11	Social Service Workers	2,022	2,194	22,932	10.45	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,165	26,329	12.16	13
14	Head Cook	6,380	6,117	52,121	8.52	14
15	Cook Helpers/Assistants	7,893	8,494	52,656	6.20	15
16	Dishwashers					16
17	Maintenance Workers	1,613	1,665	15,399	9.25	17
18	Housekeepers	16,468	17,464	115,556	6.62	18
19	Laundry	2,026	2,404	23,666	9.84	19
20	Administrator	1,960	2,080	45,507	21.88	20
21	Assistant Administrator	1,978	2,224	47,526	21.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,121	2,384	16,620	6.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify PLACEMENT (	6,388	7,077	60,386	8.53	33
34	TOTAL (lines 1 - 33)	130,279	139,566	$ 1,388,760 *	$ 9.95	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 3,500	1-3	35
36	Medical Director		1,700	9-3	36
37	Medical Records Consultant		1,320	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		1,500	10-3	39
40	Physical Therapy Consultant		5,150	10a-3	40
41	Occupational Therapy Consultant		5,400	10a-3	41
42	Respiratory Therapy Consultant		1,274	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		2,391	11-3	44
45	Social Service Consultant		5,082	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT		0	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 27,317		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

0

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
EUGENE BERGER	ADMIN	0.00%	$ 45,507
ESTELLA MAJOR	ASST ADMIN	0.00%	47,526
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,033

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 257,400
TOTAL (agree to Schedule V, line 17, col. 3)	$ 257,400
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
CARE PLUS	DATA PROCESSING	9,600
HDSI	DATA PROCESSING	770
AMERICAN DATA	DATA PROCESSING	3,675
CARE PLUS	ADMIN CONSULTANT	126,500
KBKB, Ltd.	ACCOUNTING	20,550
MEYER MAGENCE	LEGAL	438
FINKLE, MARTWICK	LEGAL	1,540
ART ROUSEAU	LEGAL	250
PERSONNEL PLANNERS	UC CONSULTANT	1,113
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 164,436

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,345
Unemployment Compensation Insurance	23,767
FICA Taxes	105,043
Employee Health Insurance	51,244
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	15,610
EMPLOYEE BENEFITS-OTHER	2,516
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 233,525

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,694
Health Care Worker Background Chec	24
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	2,959
DUES & SUBSCRIPTIONS	4,174
LICENSES & PERMITS	3,119
TRUST FEES, CONTRIBUTIONS,etc.	0
MGMT CO ALLOCATION	813
LESS TRUST FEES, CONTRIB, etc.	0
Less: Public Relations Expense	( )
Non-allowable advertising	(2,617)
Yellow page advertising	(342)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,824

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	74
Seminar Expense	
SEMINAR & EDUCATION	1,720
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,794

**See instructions.

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